SENATE BILL No. 301

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-8-11; IC 27-13-15.

Synopsis: Participating health providers. Establishes certain requirements concerning health care providers that enter into agreements with health insurers and health maintenance organizations with respect to claims, billing, and actions taken by a licensing authority against a provider.

Effective: July 1, 2004.

Drozda

January 8, 2004, read first time and referred to Committee on Health and Provider Services.

Introduced

Second Regular Session 113th General Assembly (2004)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2003 Regular Session of the General Assembly.

SENATE BILL No. 301

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-8-11-3.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: **Sec. 3.2. (a) An agreement entered into under section 3 of this chapter must:**

(1) be in writing;

(2) prohibit billing an insured for health care services for which payment by the insurer is legally required; and

(3) provide that if the insurer fails to pay the provider for health care services for which payment by the insurer is legally required, an insured is not liable to the provider for payment for the health care services.

(b) If an agreement entered into under section 3 of this chapter:

(1) is not in writing; or

(2) does not contain the provisions specified in subsection (a);

the provider may not collect or attempt to collect from an insured payments that are liabilities of the insurer.

SECTION 2. IC 27-8-11-7 IS ADDED TO THE INDIANA CODE

AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: **Sec. 7. (a) A provider that:**

(1) does not enter into an agreement under section 3 of this chapter; and

(2) provides emergency health care services to an insured;

may collect payment for the emergency health care services if the provider was unaware at the time the emergency health care services were rendered that the insured was covered under a policy issued by an insurer that provides payment for health care services under a preferred provider plan.

(b) A provider described in subsection (a) may collect only:

(1) from the insurer, the amount that would be paid for the emergency health care services to a provider who has entered into an agreement under section 3 of this chapter; and

(2) from the insured, the difference between the amount charged for the emergency health care services and the amount received from the insurer.

SECTION 3. IC 27-8-11-8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: **Sec. 8. (a) A provider that enters into an agreement under section 3 of this chapter and submits a claim to the insurer for payment for health care services provided to an insured may not bill the insured for health care services for which payment by the insurer is required.**

(b) A provider that enters into an agreement under section 3 of this chapter may bill, collect, and attempt to collect payment from an insured only for amounts specified in the insured's policy as:

(1) coinsurance;

(2) deductibles;

(3) copayments; or

(4) payments for health care services that are not covered under the policy.

(c) A statement sent to an insured by a provider that enters into an agreement under section 3 of this chapter must:

(1) clearly state the amount billed to the insurer; and

(2) contain the following language conspicuously displayed on the front of the statement in not less than 10 point boldface capital letters:

"NOTICE: THIS IS NOT A BILL. DO NOT PAY.".

(d) A bill sent to an insured by a provider that enters into an agreement under section 3 of this chapter must:

(1) clearly state any amount due that is the liability of the

insured; and

(2) contain the following language conspicuously displayed on the front of the bill in not less than 10 point boldface capital letters:

"NOTICE: YOU ARE NOT RESPONSIBLE FOR ANY AMOUNT OWED BY YOUR HEALTH INSURANCE COMPANY.".

SECTION 4. IC 27-8-11-9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: **Sec. 9. (a) A provider that demands or collects payment from an insured in violation of section 7 or 8 of this chapter shall immediately correct the billing to the insured and refund any amount paid not more than twenty-five (25) days after the provider receives service of a cease and desist order by the commissioner.**

(b) A provider that files a report with a credit reporting agency for nonpayment by an insured of any amount that the provider is prohibited from collecting under section 7 or 8 of this chapter is liable for:

(1) the provision of required documentation; and

(2) all costs, including attorney's fees and court costs;

associated with correcting the erroneous credit report.

(c) This section is not intended to conflict with the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.).

SECTION 5. IC 27-8-11-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: **Sec. 10. (a) As used in this section, "unbundling" means the use of multiple billing codes specified in IC 27-8-22.1-5 when describing individual components of a health care service rather than the use of a single comprehensive billing code that describes the entire health care service.**

(b) As used in this section, "upcoding" means billing for a health care service at a higher level than the level at which the health care service is delivered.

(c) The department of insurance shall adopt rules under IC 4-22-2 to prohibit a provider from:

(1) unbundling; and

(2) upcoding;

billing codes. The rules adopted under this subsection must be consistent with transaction codes developed by the United States Department of Health and Human Services under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320D-4), as amended.

(d) A provider that has entered into an agreement under section 3 of this chapter and is determined by the commissioner to have engaged in unbundling or upcoding is subject to the following penalties:

(1) An administrative penalty of not more than ten thousand dollars ($10,000) for each offense.

(2) A refund of all inappropriately billed charges to the insured or insurer, with interest of fifteen percent (15%) per year calculated from the date of the inappropriate billing.

SECTION 6. IC 27-8-11-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: **Sec. 11. (a) A provider that enters into an agreement under section 3 of this chapter shall submit a claim for health care services covered under a policy issued by the insurer:**

(1) not more than thirty (30) business days after the date the health care services are rendered to the insured; or

(2) according to the terms of the agreement.

If the insurer requests additional information from the provider to justify claim payment, the provider shall submit the requested information to the insurer not more than ten (10) business days after receiving the request.

(b) A provider described in subsection (a) shall request from the insurer additional time to submit a claim, if additional time is needed by the provider, not more than thirty (30) business days after the date health care services are rendered to an insured. An insurer that receives a request under this subsection shall grant an additional thirty (30) business days for the provider to submit the claim. If a provider does not submit a claim during the additional period granted under this subsection, the insurer is not required to provide payment to the provider for the claim.

(c) An insurer may deduct ten percent (10%) of the total cost of a claim for every business day that a provider that enters into an agreement under section 3 of this chapter fails to submit a claim after the initial thirty (30) business day period specified in subsection (a) plus sixty (60) business days if the provider:

(1) fails to submit the claim less than thirty-one (31) days after the date the health care services are rendered to an insured; and

(2) has not requested an extension described in subsection (b).

(d) If a provider fails to submit a claim less than thirty-one (31) days after the date health care services are rendered to an insured, IC 27-8-5.7 does not apply to the claim.

(e) If an insurer:

(1) is not required to provide payment to a provider under subsection (b); or

(2) is permitted to deduct an amount from the total cost of a claim under subsection (c);

the provider shall not bill the insured for any amount that would have been paid by the insurer if the provider had met the requirements of this section.

SECTION 7. IC 27-8-11-12 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: **Sec. 12. (a) As used in this section, "board" has the meaning set forth in IC 25-1-5-2.**

(b) If a board:

(1) takes action; or

(2) receives a report of an adverse action taken by a hospital or professional review committee;

against a provider who is licensed, certified, registered, or permitted by the board to act under IC 25, the board shall notify an insurer that has provided to the board a point of contact and requested that the board notify the insurer's point of contact of actions against providers that have entered into an agreement under section 3 of this chapter.

(c) An insurer may designate whether the notice required under subsection (b) must be sent in written or electronic form.

(d) A board shall provide the notice required under subsection (b) not more than ten (10) days after the end of the month in which the:

(1) action was taken; or

(2) report was received;

by the board.

(e) Notice required under subsection (b) must:

(1) specify the action taken against the provider;

(2) specify the date on which the action is effective;

(3) specify corrective actions taken by the board, including obtaining additional continuing education credits or other training requirements; and

(4) not provide any individually identifiable health information with respect to a patient of the provider.

(f) A limitation, restriction, suspension, or termination imposed by an insurer on an agreement entered into under section 3 of this chapter is effective on the date on which notice required under subsection (b) is received by the insurer if:

(1) the insurer determines that the provider:

(A) poses an imminent threat to the health or safety of an insured; or

(B) has:

(i) engaged in fraudulent activities with respect to the insurer;

(ii) provided false or misleading information to the insurer; or

(iii) withheld information from the insurer concerning matters related to the professional conduct or qualifications of the provider; or

(2) the action about which the insurer was notified under subsection (b) removes or significantly impairs the ability of the provider to render health care services to an insured.

(g) An insurer that terminates, suspends, restricts, or limits an agreement entered into under section 3 of this chapter based on the notice required under subsection (b) is not subject to the requirements of section 3(c) of this chapter.

(h) A provider who is the subject of an action by an insurer to terminate, suspend, restrict, or limit an agreement entered into under section 3 of this chapter that is based on the notice required under subsection (b) has no cause of action against the insurer arising from the insurer's action.

(i) This section does not require an insurer to take any action based on the notice received by the insurer under subsection (b).

SECTION 8. IC 27-13-15-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: Sec. 1. (a) A contract between a health maintenance organization and a participating provider of health care services:

(1) must be in writing;

(2) may not prohibit the participating provider from disclosing:

(A) the terms of the contract as it relates to financial or other incentives to limit medical services by the participating provider; or

(B) all treatment options available to an insured, including those not covered by the insured's policy;

(3) may not provide for a financial or other penalty to a provider for making a disclosure permitted under subdivision (2); ~~and~~

(4) must provide that in the event the health maintenance organization fails to pay for health care services as specified by the contract, the subscriber or enrollee is not liable to the participating provider for any sums owed by the health

maintenance organization; **and**

(5) must prohibit billing an enrollee for health care services for which the health maintenance organization is liable.

(b) An enrollee is not entitled to coverage of a health care service under a group or an individual contract unless that health care service is included in the enrollee's contract.

(c) A provider is not entitled to payment under a contract for health care services provided to an enrollee unless the provider has a contract or an agreement with the carrier.

(d) This section applies to a contract entered, renewed, or modified after June 30, 1996.

SECTION 9. IC 27-13-15-4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: **Sec. 4. (a) A provider that:**

(1) is not a participating provider; and

(2) provides emergency health care services to an enrollee;

may collect payment for the emergency health care services if the provider was unaware at the time the emergency health care services were rendered that the enrollee was covered under a contract with a health maintenance organization.

(b) A provider described in subsection (a) may collect only:

(1) from the health maintenance organization, the amount that would be paid for the emergency health care services to a participating provider; and

(2) from the enrollee, the difference between the amount charged for the emergency health care services and the amount received from the health maintenance organization.

SECTION 10. IC 27-13-15-5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: **Sec. 5. (a) A participating provider that submits a claim to a health maintenance organization for payment for health care services provided to an enrollee may not bill the enrollee for health care services for which the health maintenance organization is liable.**

(b) A participating provider may bill, collect, and attempt to collect payment from an enrollee only for amounts specified in the enrollee's contract with a health maintenance organization as:

(1) coinsurance;

(2) deductibles;

(3) copayments; or

(4) payments for health care services that are not covered under the contract.

(c) A statement sent to an enrollee by a participating provider must:

(1) clearly state the amount billed to the health maintenance organization; and

(2) contain the following language conspicuously displayed on the front of the statement in not less than 10 point boldface capital letters:

"NOTICE: THIS IS NOT A BILL. DO NOT PAY.".

(d) A bill sent to an enrollee by a participating provider must:

(1) clearly state any amount due that is the liability of the enrollee; and

(2) contain the following language conspicuously displayed on the front of the bill in not less than 10 point boldface capital letters:

"NOTICE: YOU ARE NOT RESPONSIBLE FOR ANY AMOUNT OWED BY YOUR HEALTH MAINTENANCE ORGANIZATION.".

SECTION 11. IC 27-13-15-6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: **Sec. 6. (a) A provider that demands or collects payment from an enrollee in violation of section 4 or 5 of this chapter shall immediately correct the billing to the enrollee and refund any amount paid not more than twenty-five (25) days after the provider receives service of a cease and desist order by the commissioner.**

(b) A provider that files a report with a credit reporting agency for nonpayment by an enrollee of any amount that the provider is prohibited from collecting under section 4 or 5 of this chapter is liable for:

(1) the provision of required documentation; and

(2) all costs, including attorney's fees and court costs;

associated with correcting the erroneous credit report.

SECTION 12. IC 27-13-15-7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: **Sec. 7. (a) As used in this section, "unbundling" means the use of multiple billing codes specified in IC 27-13-41-1 when describing individual components of a health care service rather than the use of a single comprehensive billing code that describes the entire health care service.**

(b) As used in this section, "upcoding" means billing for a health care service at a higher level than the level at which the health care service is delivered.

(c) The department of insurance shall adopt rules under IC 4-22-2 to prohibit a provider from:

(1) unbundling; and

(2) upcoding;

billing codes. The rules adopted under this subsection must be consistent with transaction codes developed by the United States Department of Health and Human Services under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320D-4), as amended.

(d) A participating provider that is determined by the commissioner to have engaged in unbundling or upcoding is subject to the following penalties:

(1) An administrative penalty of not more than ten thousand dollars ($10,000) for each offense.

(2) A refund of all inappropriately billed charges to the enrollee or health maintenance organization, with interest of fifteen percent (15%) per year calculated from the date of the inappropriate billing.

SECTION 13. IC 27-13-15-8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: **Sec. 8. (a) A participating provider shall submit a claim for health care services covered under a contract with a health maintenance organization:**

(1) not more than thirty (30) business days after the date the health care services are rendered to the enrollee; or

(2) according to the terms of the participating provider's contract with the health maintenance organization.

If a health maintenance organization requests additional information from a participating provider to justify claim payment, the participating provider shall submit the requested information to the health maintenance organization not more than ten (10) business days after receiving the request.

(b) A participating provider described in subsection (a) shall request from the health maintenance organization additional time to submit a claim, if additional time is needed by the participating provider, not more than thirty (30) business days after the date health care services are rendered to an enrollee. A health maintenance organization that receives a request under this subsection shall grant an additional thirty (30) business days for the participating provider to submit the claim. If a participating provider does not submit a claim during the additional period granted under this subsection, the health maintenance organization

is not required to provide payment to the participating provider for the claim.

(c) A health maintenance organization may deduct ten percent (10%) of the total cost of a claim for every business day that a participating provider fails to submit a claim after the initial thirty (30) business day period specified in subsection (a) plus sixty (60) business days if the participating provider:

(1) fails to submit the claim less than thirty-one (31) days after the date health care services are rendered to an enrollee; and

(2) has not requested an extension described in subsection (b).

(d) If a participating provider fails to submit a claim less than thirty-one (31) days after the date health care services are rendered to an enrollee IC 27-13-36.2 does not apply to the claim.

(e) If a health maintenance organization is:

(1) not required to provide payment to a participating provider under subsection (b); or

(2) is permitted to deduct an amount from the total cost of a claim under subsection (c);

the participating provider may not bill the enrollee for any amount that would have been paid by the health maintenance organization if the participating provider had met the requirements of this section.

SECTION 14. IC 27-13-15-9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: **Sec. 9. (a) As used in this section, "board" has the meaning set forth in IC 25-1-5-2.**

(b) If a board:

(1) takes action; or

(2) receives a report of an adverse action taken by a hospital or professional review committee;

against a participating provider who is licensed, certified, registered, or permitted by the board to act under IC 25, the board shall notify a health maintenance organization that has provided to the board a point of contact and requested that the board notify the health maintenance organization's point of contact of such actions against participating providers.

(c) A health maintenance organization may designate whether the notice required under subsection (b) must be sent in written or electronic form.

(d) A board shall provide the notice required under subsection (b) not more than ten (10) days after the end of the month in which the action was taken or the report was received by the board.

(e) Notice required under subsection (b) must:

(1) specify the action taken against the participating provider;

(2) specify the date on which the action is effective;

(3) specify corrective actions taken by the board, including obtaining additional continuing education credits or other training requirements; and

(4) not provide any individually identifiable health information with respect to a patient of the participating provider.

(f) A limitation, restriction, suspension, or termination imposed by a health maintenance organization on a contract entered into with a participating provider under this chapter is effective on the date on which notice required under subsection (b) is received by the health maintenance organization if:

(1) the health maintenance organization determines that the participating provider:

(A) poses an imminent threat to the health or safety of an enrollee; or

(B) has:

(i) engaged in fraudulent activities with respect to the health maintenance organization;

(ii) provided false or misleading information to the health maintenance organization; or

(iii) withheld information from the health maintenance organization concerning matters related to the professional conduct or qualifications of the participating provider; or

(2) the action about which the health maintenance organization was notified under subsection (b) removes or significantly impairs the ability of the participating provider to render health care services to an enrollee.

(g) A participating provider who is the subject of an action by the health maintenance organization to terminate, suspend, restrict, or limit a contract entered into under this chapter that is based on the notice required under subsection (b) has no cause of action against the health maintenance organization arising from the health maintenance organization's action.

(h) This section does not require a health maintenance organization to take any action based on the notice received by the health maintenance organization under subsection (b).